Handout 4-4: CID Report Template

Community Identification (CID) Report Content

I. Introduction – HALF **PAGE**
   A. Introduction to Community PROMISE Project
      1. Why are you doing PROMISE?
      2. Perceived need for PROMISE in your locality (problem statement in a logic model)
   B. Funding source
   C. Expected outcomes

II. Description of CID Process and Results: - **TWO-THREE PAGES**
   A. Selection of implementation site (geographic area to do the intervention)
   B. Brief summary of number of each type of interview/focus group conducted
      1. Interviews (internal and external)
      2. Focus groups
   C. Description of 7 Objectives of CID – main results for each
      1. Understand the target population and its subgroups
         a) Target population
         b) Segments – demographics and other characteristics
         c) Process of prioritization
         d) Selection of intervention population – description and justification
      2. Identify intervention population's specific risk behaviors, risk factors and the contexts in which they occur.
         a) Risk behaviors
         b) Risk factors
         c) Behavioral determinants of risk or influencing factors
      3. Identify barriers to behavior change and how they might be overcome
         a) Access, cost, lack of information
         b) Other barriers
      4. Establish a presence and build trust
         a) How did you do it?
         b) How is it evidenced?
      5. Learn from the intervention population about what are appropriate and acceptable risk reduction messages
         a) Suggestions for messages and things to avoid
      6. Develop a plan for accessing intervention population based on 15% criteria
         a) Estimation of intervention population size (how many people from my target population are in my implementation site?)
         b) How did you gain access
         c) Plan for utilizing access methods
      7. Elicit support from other organizations and develop a referral network
         a) Partnering
         b) Peer and Community Advocates
         c) Referral network members

III. Community Staging Process: Findings – **HALF PAGE [use the key informant interview here]**

IV. Role Model Stories: **- ONE PAGE**

A. Brief description of each initial role model story based on 8 key components
   1. Risk behavior, goal behavior, stage of change, behavioral determinant, and barrier to change/method to overcome, characterization, membership, positive outcome) OR
   2. Risk factors using the HIV continuum of care indicators you want to use
   3. Results of piloting of initial role model stories with community advisory group for format

V. Peer Advocates – **ONE PAGE**

A. Plans for recruitment of Peer Advocates
B. Training plans for Peer Advocates
C. Retention plans for Peer Advocates

VI. Plans for Evaluation – plan for revisiting CID data, every 6-9 months – **HALF PAGE [just state here you want to stage every 3 or 6 months so you will develop new RMS]**

VII. Appendix

A. Include final examples of initial role model stories
B. Include specific tools used (especially if they have been adapted)
C. Timeline for full implementation

Sample CID Report

INTRODUCTION

Based on a review of our town's STD and HIV rates and other demographic information, Wellness Resource Center (WRC) determined that the disease rates were highest in the neighborhood and among young adult African Americans, both male and female. This area also has high drug-related crime rates and a number of apartment complexes. Our agency has provided family planning and basic health education to young adult African Americans in this area in the past, so we have established relationships with other service providers and the staff felt comfortable working with this target population. Our experience told us that this target population has low condom use, due to negative attitudes, low risk perception, misconceptions about HIV transmission, and unsupportive community norms for condom use with casual partners. We examined a number of effective behavioral interventions and compared the behavioral determinants addressed by each with the information we had about the target population. We decided to implement a community-level intervention, since we felt this would be the best way to address the community norms around condom use and impact the largest number of people with our limited funds.

WRC requested and received funding of $350,000 per year for five years to implement the Community PROMISE intervention with a subpopulation of African American heterosexual men and women, ages 21-35. The expected outcomes are: an increase in personal risk perception for HIV and other STDs, correct knowledge of HIV transmission, increased positive and decreased negative attitudes toward condom use, and increasingly supportive norms for condom use. We also expect to see increased condom carrying and an increase in reported use of condoms for vaginal sex from both men and women.

DESCRIPTION OF CID PROCESS AND RESULTS

Site selection

As noted above we selected the Mayfield neighborhood as out target population area based on our knowledge of the neighborhood and the disease rates reported in the residents. We used an abbreviated version of the ethnographic technique of community identification, conducting a number of formal qualitative interviews with people who serve the community members, work closely with them, and are gatekeepers to the community Additionally, participants were allowed the opportunity to voice their thoughts, beliefs, opinions, ideas and experience in a more relaxed and non-threatening atmosphere through focus groups, thus allowing for a more in-depth, understanding of their risk for HIV and the circumstances surrounding those risks.

Interviews/focus groups

Based on discussions with systems people, business owners, key observers, gatekeepers, and members of the target population, as well as anecdotal data and information found in existing literature sources, the WRC staff refined the PROMISE key participant survey instrument to explore issues connected to understanding the social norms related to existing HIV risk behaviors and the factors impacting them.

As of February 2011 the WRC staff has completed 35 systems, interactor, key observer, and gatekeeper interviews, starting with five people known by agency staff and following the referrals to others. We then completed 45 key participant interviews with residents of the Stewart Hills apartment complex. The respondents were all African American and included both males (19) and females (26) respondents. We also held 5 focus groups (2 of men and 3 of women) of young adults living in Stewart Hills. It took us nine months to complete the CID.

CID Objectives

1. Target population, segments, prioritization, intervention population

We started the CID process with the target population of African American men and women living in the Mayfield neighborhood, age 21-35. The Community Access Survey respondents identified several segments of this community, all having vaginal sex: men and women who have casual partners, women who trade sex for drugs and alcohol, men who have sex with sex trading women, and men and women who use injection drugs and may or may not trade sex for drugs. Based on WRC's expertise and experience, the rates of repeated STDs, and lower barriers to accessing the segment members, WRC chose as its intervention population, African American heterosexual men and women, age 21-35 who live in the Stewart Hills apartment complex and have unprotected vaginal sex with casual partners, primarily in Johnson Park and at Kool Kats Club. WRC staff have no experience working with injection drug users but at least two staff have personal contacts in Stewart Hills and a history of providing health promotion messages there.

2. Intervention population risk behaviors, risk factors, behavioral determinants

There was a range of risk behaviors identified by survey respondents, including unprotected vaginal sex with main, casual, and paying partners, as well as needle sharing. Unprotected vaginal sex with casual partners was named more frequently than any other behaviors (n=43).There were also a number of respondents who identified sex more generally as a risk behavior (n=21) without qualifying further what type of sex. These responses were counted separately to capture the nuances in the data and provide as much detail as possible for the purposes of planning future programs. It is important to note these subtle differences as it suggests that even when speaking about unprotected sex as a risk behavior among the target population, there are persisting misconceptions about the transmission of HIV.

Seventy-nine percent of respondents indicated that they did not use a condom the last time they had sex. Some of the reasons provided ranged from trusting their partner to disliking condoms. The most common reason named was sex felt better without a condom (n=43).

For approximately 36% of respondents, alcohol or drugs is sometimes involved when they're having sex, a factor that might influence this group's decision to use protection. Of those who reported that they used drugs when having sex, the only drug named was marijuana or weed. Needle use was not identified as an issue among survey respondents.

There was a general perception among the intervention population that they were not at risk for HIV infection. Approximately 82% of respondents reported that it was not likely they could become infected with HIV, with a majority explaining that they were unlikely to become infected because they did not have a partner at risk. Most troubling are the reasons given by a small minority of respondents who felt that they were "untouchable" or it just wouldn't happen to them.

3. Barriers and methods to overcome barriers

The primary barriers described by respondents to our being successful in our work were the police presence in and near both Johnson Park and Kool Kats Club and the strong belief that people in the neighborhood were not at risk for HIV. The police presence was noted also in our observations. Since we plan on only distributing condoms and role model stories ourselves and through our peer advocates we are not planning on coming into contact with illegal activities. We do recognize that trading for sex and drugs is also occurring in the neighborhood and the police could likely associate our work with illegal behavior. We have established initial contact through our CID process with police who work out of the substation in the neighborhood and all staff will visit the station and make themselves known to the police. We will also work with the police department team in the Mayfield substation to help us identify further best times and places to conduct outreach without being part of illegal activities.

The very low perception of risk and, in some cases, absolute denial of risk make our job more difficult in that we have to start with moving some portions of the community out of the pre-contemplative stage. We will wear away at these beliefs over time with stories of persons from the intervention population who are willing to speak out about their HIV status. We will also look for African Americans from the Mayfield neighborhood who are living with HIV who will speak at community events, have their story published in a role model story, and generally be public about their story. If necessary, to raise risk perception, we will use stories from other PROMISE implementations so that we can have real-sounding stories about becoming infected with HIV.

4. Establishing presence and trust

The combination of our initial reputation in the community and the detailed CID process we completed have worked together to create an increased presence in the community for the WRC staff. We spent over 250 hours in the Stewart Hills apartment complex, conducting key participant interviews and observations. We were present at all times of the day and night, seven days a week. We also talked to people at all the systems agencies and local stores in the immediate neighborhood and sought out key observers and gatekeepers as we were referred to them. We followed referrals to several gatekeepers who proved to be key to our acceptance in two major social networks. As noted in this report there are several non-overlapping social networks that have to be reached independently. The CID process helped us meet people we would have missed otherwise and gave us credibility as we spoke with others to whom the first people had referred us.

5. Acceptable and unacceptable messages and means of access

The most effective way to reach members of the intervention community is through friends and family; close to 47% of respondents look to friends and family for news or information about what's going on in their community. 32% of survey respondents reported that they find out what's happening in their community through the local newspaper because they like knowing about upcoming events.

It is unclear whether brochures or pamphlets are an effective means for communicating with the intervention population as 43% indicated that they read brochures and slightly less (41%) indicated that they did not. When asked specifically whether they would read the role model publication, the majority (61%) responded "yes" and 32% responded "no."

Members of the intervention community can be reached primarily hanging out in their neighborhood (23%) or at home (18%) and hanging out with friends, including a girl/boyfriend (54%) or family (35%). There were also a number who spent their free time hanging out a local park (Johnson Park), basketball courts or other entertainment venues such as the Kool Kats Club and the bowling alley.

6. Estimate of intervention population size and plans to access the 15%

We estimate the total intervention population to be 800 people based on resident data from the Stewart Hills apartment management, so our 15% goal is to reach 120 people every four weeks (the time period agreed upon with our funder). We will do this through careful recruitment of peer advocates as described below.

7. **Community partners: community advocates, referral network**

WRC has an already well established referral network with partner agencies that provide financial assistance, food, clothing job training, STD diagnosis and treatment, HIV testing and linkage to care, drug treatment and mental health services. We are in the process of re-contacting each agency to confirm the referral process and update any agreements in place. There are a number of community businesses in the immediate area of Stewart Hills, several of which have employees who participated in our Community Access Survey. We will build on that trust and access to further the mobilization effort and involve them in our community events and as distribution points for condoms and materials. We are especially interested in businesses which can contribute food and other items necessary for successful block parties in the apartment complex.

COMMUNITY STAGING RESULTS

The predominant "stage of change" among the intervention population as it relates to condom use for vaginal sex with their casual or anonymous partners is contemplation. Sixty-nine percent of survey respondents reported that they had never used a condom but were thinking of using one in the near future. The percentage in contemplation for men was 70% and for women was 65%.

Table 1. Condom Use

Stage of Change	Number Interviewed	Proportion
Precontemplation	7	15%
Contemplation	31	69%
Preparation	4	9%
Action	3	7%
Maintenance	0	0%

INITIAL ROLE MODEL STORIES

Initial role models have been identified during the CID process and 5 men and 4 women have agreed to provide their stories, all persons currently in preparation for condom use for vaginal sex with casual partners. Six persons have already been interviewed and those stories are in the early stages of production. We held two meetings of our 15 member community advisory group to obtain feedback on a variety of formats, styles, and looks for the role model story publications. At the first session we presented six different format and style combinations and the group overwhelmingly preferred a combination of three of the versions. So we held a second meeting to present the new version and obtained enthusiastic approval of a neighborhood newspaper format with the role model stories as the main items but with other brief news and announcement

sections of general interest to the neighborhood. The group members also strongly preferred photographs of real people for illustrations.

We will distribute 120 copies of the first four role model stories over a four week period. We will create at least five new role model stories every four weeks. We have begun recruiting role models and plan to begin distribution of the first round of role model stories by the beginning of Year Two of our funding cycle.

PEER ADVOCATE PLANS

We have been able to recruit six possible peer advocates, members of three different social networks. In our CID process we identified at least 12 social networks in the Stewart Hills apartment complex so we will continue to follow our leads to those remaining networks and recruit additional peer advocates. Our plan is to have a total of 15 peer advocates at any one time to cover our networks. This is more than indicated by following the 15% formula but necessary to reach members of the non-overlapping networks in the neighborhood.

We are developing a two-hour initial training curriculum which will follow the outline provided in the Community PROMISE course. Given the extent of misconceptions about HIV transmission, we will spend an additional session on myths and facts of HIV. After the peer advocates have completed these training sessions, they will each conduct outreach and role model story distribution with a WRC staff member for a minimum of four hours over two days so that the staff feel comfortable with their skills.

Our plan for retention of peer advocates involves monthly community mobilization events with the peers taking leadership roles in the planning and implementation, periodic recognition of the contribution of time and energy, gift cards and incidental items, birthday and other personal date recognition, and weekly phone or other contacts.

PLANS FOR ONGOING EVALUATION

After 12 months of full implementation we will conduct our first round of Ongoing Evaluation Surveys with members of the intervention population. We will attempt to interview a minimum of 50 people, divided evenly between males and females. We will be especially interested in the stage of change for condom use with vaginal sex with casual partners, exposure to our program materials and staff/advocates, condom carrying, and reported changes in the behavioral determinants related to condom use.

APPENDIX

Initial role model stories

Specific adapted tools

Timeline